Statement of
the Honorable Robert H. Roswell, MD
Under Secretary for Health
Department of Veterans Affairs
On
VA's Long-Term Care Programs
Before the
Committee on Veterans' Affairs
U. S. House of Representatives
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Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the continued enhancement of VA's long-term care programs. With me today is Dr. James F. Burris, VA's Chief Consultant for the Geriatrics and Extended Care Strategic Healthcare Group.

Mr. Chairman, we have testified previously that the need for effective and accessible long-term care services for veterans cannot be overstated. The number of veterans age 75 and older is projected to increase from 4 million to 4.5 million between 2000 and 2010, and the number of those over 85 to triple to 1.3 million during the same period. These veterans, particularly those over 85, are the most vulnerable of the older veteran population and are especially likely to require not only long-term care, but also health care services of all types. Typically, VA's patients are not only older in comparison to the general population, but they generally have lower incomes, lack health insurance, and are much more likely to be disabled and unable to work. The projected peak in the number of elderly veterans during the first decade of this century will occur approximately 20 years in advance of that in the general U.S. population. Thus the current demographics of the veteran population are one of the major driving forces in the design of the VA health care system.

As the VA health care system redefined itself in recent years as a "health care" system instead of a "hospital" system, VA's approach to geriatrics and extended care evolved from an institution-focused model to one that is patient-centered. While VA remains committed to providing long-term care for eligible veterans who need it institutional long-term care is very costly and is likely to impair long-standing

relationships with friends, family, spouse, and community and reduce overall quality of life. We believe that long-term care should focus on the patient and his or her needs, not on institutions or particular programs. Such a patient-centered approach supports the wishes of most patients to live at home and in their own communities for as long as possible. Therefore, newer models of long-term care, both in VA and outside of VA, include a continuum of home and community-based extended care services in addition to nursing home care.

I announced plans to establish a new Office of Care Coordination in testimony before the Subcommittee on Health last May. I am pleased to report that the office is now fully operational. Care coordination involves the ongoing monitoring and assessment of selected patients using telehealth technologies to proactively enable prevention, investigation, and treatment that enhances the health of patients and prevents unnecessary and inappropriate utilization of resources. Care coordination uses best practices derived from scientific evidence to bring together health care resources from across the continuum of care in the most appropriate, effective, and efficient manner to care for the patient. Care coordination provides patients a continuous connection to clinical services from the convenience of their place of residence. Also, those family members and others who provide care in the home are supported in their critical and difficult roles.

Initial efforts in Care Coordination are focusing on high resource utilization patients with chronic diseases such as diabetes, congestive heart failure, chronic pulmonary disease, depression, post-traumatic stress disorder, spinal cord injury, and wound care. On the basis of a needs assessment performed in April 2002, we anticipate that each VISN should manage between 1,000 and 1,500 such patients using home telehealth and disease management to support care. The emphasis of these programs is to support the non-institutional care of veteran patients and to promote their independent living. Episodic links to care at hospitals and clinics are augmented with continuous monitoring of the veteran's health status, which permits active intervention at an earlier stage of disease progression. These services are designed to link with existing home and community-based programs, including home-based primary care, (HBPC), mental health intensive case management (MHICM), and general primary and

ambulatory care services. The average daily census in Care Coordination has grown from 2,000 patients in FY 2002 to over 3,000 currently, with a goal of 7,500 by the end of this fiscal year.

VA also continues to make progress in expanding its more traditional home and community-based non-institutional extended care programs, while retaining its three nursing home programs (VA, Contract Community, and State Homes), as recommended by the Federal Advisory Committee on the Future of Long-Term Care in VA in its 1998 report, "VA Long Term Care at the Crossroads". From 1998 to 2003, the average daily census (ADC) in VA's home- and community-based non-institutional care increased from 11,706 to 18,322. VHA has a budget performance measure that calls for an ambitious 24 percent increase in the number of veterans receiving home and community-based care between FY 2003 and FY 2004. Non-institutional home and community-based care workload has also been established as a VHA Performance Measure and is reported in the Monthly Performance Report along with the nursing home workload. Each VISN has been assigned targets for increases in their non-institutional LTC workload. VA plans to achieve a level of 22,242 ADC in home- and community-based programs in FY 2004, exclusive of the Care Coordination census. VA will expand both the services it provides directly and those it purchases from affiliates and community partners. VA expects to meet most of the new need for long-term care through care coordination, home health care, adult day health care, respite, and home-maker/home health aide services. Attachment 1 to my statement documents the growth in actual and projected workload from 1998 through 2004 in VA's non-institutional long-term care programs.

VA has several additional initiatives in progress or planned in response to last year's GAO report, "VA Long Term Care – Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care" (GAO-03-487). We have issued a new Respite Care Handbook to provide guidance to VA field facilities, and have several other handbooks and directives in concurrence or final drafts. A workgroup is refining VA's long-term care planning model and expects to have a final product later this year. Several training initiatives were completed last year and more are underway. And, of

course, we are continuing the congressionally mandated pilots on Assisted Living and comprehensive long-term care for the elderly.

VA also continued to make progress during FY 2003 in restoring the VA Nursing Home Care Unit average daily census to the 1998 baseline mandated by the Millennium Act. However, as recommended by the "Crossroads Report", most of the growth in nursing home beds occurred in the State Veterans Home program. We believe that nursing home care should be reserved as a last resort for situations in which a veteran can no longer safely be cared for in home and community-based settings and when appropriate to provide post-acute care. We again urge the Committee to allow VA to count the census in all of our extended care programs toward meeting the capacity requirements of the Millennium Act.

Mr. Chairman, VA's plans for long-term care include an integrated care coordination system incorporating all of the patient's clinical care needs; more care in home- and community-based settings, when appropriate to the needs of the veteran; emphasis on research and educational initiatives to improve delivery of services and outcomes for VA's elderly veteran patients; and development of new models of care for diseases and conditions that are prevalent among elderly veterans as well as a commitment to institutional long-term care when this best serves the needs of veterans. VA is leveraging its leadership in computerization and advanced technologies to better provide patient-centric care.

This completes my statement. I will now be happy to address any questions that you and other members of the Subcommittee might have.

Attachment 1

NON-INSTITUTIONAL LONG-TERM CARE, AVERAGE DAILY CENSUS 1998-2004

	ACTUAL						EST.
	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Home Based Primary Care	6348	6828	7312	7803	8081	8370	9877
Purchased Skilled Home Care	1916	2167	2569	3273	3845	4336	5116
VA Adult Day Health Care	442	462	453	446	427	320	378
Contract Adult Day Health Care	615	809	697	804	932	901	1063
Homemaker/Home Health Aide Services	2385	3141	3080	3824	4180	4316	5093
Home Respite						2	300
Home Hospice						77	415
Non-Institutional Care Total	**11706**	**13407**	**14111**	**16150**	**17465**	**18322**	**22242**